

Medical Assistance Administration



Speech/Audiology Program

**Billing Instructions
for
Audiologists and Speech-Language Pathologists**

(WAC 388-545-0700)

July 1999

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About this publication

This publication supersedes all previous billing instructions for Speech Therapy Services. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Hearing Aids and Services
- Home Health Services
- School Medical Services
- Neurodevelopmental Centers
- Outpatient Hospital

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
July 1999

**Received too many billing instructions?
Too few?**

Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

How do I apply for a provider number?

Call the Provider Enrollment Unit according to the first letter of your business name:

A-H (360) 664-0300
I-O (360) 753-4712
P-Z (360) 753-4711

Where do I send hardcopy claims?

Division of Program Support
PO Box 9248
Olympia WA 98507-9248

How do I request billing instructions?

Check out our website:

<http://maa.dshs.wa.gov>

or write/call:

Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
1-800-562-6188

Who do I call if I have questions regarding...

Policy, payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic billing?

(360) 753-0318

or write to:

Electronic Billing
PO Box 45564
Olympia, WA 98504-5564

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Client - An applicant for, or recipient of, DSHS medical care programs.

Department - The state Department of Social and Health Services (DSHS). (WAC 388-500-0005)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) - A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Health Care Financing Administration Claim Form (HCFA-1500) - A claim form used to bill for Medicaid services.

Health Maintenance Organization (HMO) - An entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis. (WAC 388-500-0005)

Managed Care - A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With or assigned to a primary care provider;
- With or assigned to a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care. (WAC 388-538-001)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to person's eligible for the:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320. (WAC 388-500-0005)

Medical Assistance Administration (MAA) - The administration within the Department of Social and Health Services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance Identification

(MAID) card – MAID cards are the forms DSHS use to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, 'course of treatment' may include mere observation or, where appropriate, no treatment at all. (WAC 288-500-0005)

Primary Care Case Manager (PCCM) –

A physician, Advanced Registered Nurse Practitioner, or Physician Assistant who provides, manages, and coordinates medical care for an enrollee. The PCCM is reimbursed fee-for-service for medical services provided to clients as well as a small, monthly, management fee.

Program Support, Division of (DPS) - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Program Visits – Visits based on CPT™ code description. Visits may or may not include time.

Provider, or Provider of Service -

An institution, agency, or person:

- (a) Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- (b) Eligible to receive payment from the department. (WAC 388-500-0005)

Provider Number - A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with the Medical Assistance Administration.

Remittance and Status Report -

A report produced by the claims processing system in the MAA Division of Program Support that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. (42 CFR 433.136)

Usual and Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed 1) the usual and customary charge that you bill the general public for the same services, or 2) if the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

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Client Eligibility

Who is eligible? [WAC 388-545-0700 (2)]

Clients presenting MAID cards with the following identifiers are eligible for services under the Speech/Audiology Program:

- **CNP** (Categorically Needy Program)
- **Children's Health**
- **GA-U No Out of State Care** (General Assistance-Unemployable)
- **Detox** (Alcoholism and Drug Addiction Treatment and Support Act)
- **LCP-MNP** (Limited Casualty Program-Medically Needy Program)
 - ✓ Only clients 20 years of age or younger; or
 - ✓ Clients receiving home health care services only
- **Emergency Hospital And Ambulance Only** (Medically Indigent Program)
 - ✓ Hospital Setting Only

Who is not eligible?

Clients presenting MAID cards with the following identifiers are not eligible for services under the Speech/Audiology Program:

- **Family Planning Only** (Limited Coverage)
- **QMB Medicare Only**

Are clients enrolled in managed care eligible?

YES! Clients with an identifier in the HMO column on their MAID card are enrolled in one of MAA's Healthy Options managed care plans and must receive all speech/audiology services directly through their Primary Care Provider (PCP). Clients can contact their PCP by calling the telephone number located on their MAID card.

Coverage

MAA pays only for covered speech/audiology services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- For conditions which are the result of medically recognized diseases and defects;
- Medically necessary, as determined by a health professional; and
- Begun within 30 days of the date prescribed.

What is covered? [WAC 388-545-0700 (3)]

Unlimited speech/audiology visits for clients 20 years of age and younger.

MAA covers the following services per client, per calendar year:

- One (1) medical diagnostic evaluation;
- A second medical diagnostic evaluation at the time of discharge for the following HCPCS diagnoses codes:

HCPCS Diagnosis Code	Description
348.1	Anoxic brain damage
436	Acute, ill-defined, cerebrovascular disease
852-852.5	Subarachnoid, subdural, and extradural hemorrhage, following injury
854, 854.1	Intracranial injury of other and unspecified nature;

- Twelve (12) speech/audiology program visits; and
- Twenty-four (24) additional speech/audiology program visits (see next page).

Additional Coverage (Client 21 years of age and older)

[WAC 388-545-0700 (4)(e)]

MAA will cover a maximum of 24 speech/audiology program visits in addition to the original 12 visits only when billed with one of the following **principle** HCPCS diagnosis codes.

<u>HCPCS Diagnosis Codes</u>	<u>Condition</u>
237.7-237.72	Neurofibromatosis
315.3-315.39, 315.5-315.9, 317-319	Medically necessary conditions for developmentally delayed clients
315.4,	Severe oral/motor dyspraxia
335.20	Amyotrophic lateral sclerosis (ALS)
340	Multiple sclerosis
343-343.9	Cerebral palsy (CP)
344.0	Quadriplegia
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)
436	Acute, but ill-defined, cerebrovascular disease
741.9	Meningomyelocele
749-749.25	Cleft palate and cleft lip
758.0	Down's syndrome
781.3	Lack of coordination
784.3	Severe aphasia
784.5	Other speech disturbance (severe Dysarthria)
787.2	Severe dysphagia
800-800.9	Fracture of vault of skull
801-801.9	Fracture of base of skull
803-803.9	Other and unqualified skull fractures
804-804.9	Multiple fractures involving skull or face with other bones
806.0-806.19	Fracture of cervical column, closed or open
807.5	Fracture of larynx and trachea, closed
807.6	Fracture of larynx and trachea, open
851.1-851.9	Cerebral laceration and contusion
852-852.5	Subarachnoid, subdural, and extradural hemorrhage, following injury
853-853.1	Other and unspecified intracranial hemorrhage, following injury
854-854.1	Intracranial injury of other and unspecified nature
900-900.9	Injury to blood vessels of head and neck
941.33,941.35,941.38, 941.43,941.45,941.48, 941.53,941.55,941.58	Severe burn of face, head, and neck
946.3-946.5	Burns of multiple specified sites
947.0-947.2	Burn of internal organs
952.0-952.09	Spinal cord injury without evidence of spinal bone injury-cervical

Are school medical services covered?

MAA covers speech/audiology services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to MAA's School Medical Services Billing Instructions. (See *Important Contacts*.)

What is not covered? [WAC 388-545-0700 (6)]

MAA does not cover speech/audiology services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

Speech-Language Pathology

For MAA to pay for speech-language therapy, a client must have a medically recognized disease or defect which requires speech-language therapy services.

Who is eligible to provide speech-language therapy? **[WAC 388-545-0700 (1)(a)(b)]**

Speech-language therapy must be provided by a speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Language, and Hearing Association or by an individual who has completed the equivalent educational and work experience necessary for such a certificate.

Swallowing Evaluations

Swallowing (dysphagia) evaluations must be performed by a speech-language pathologist who:

- Holds a master's degree in speech-language pathology; and
- Has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

A swallowing evaluation includes:

- An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing;
- Dietary recommendations for oral food and liquid intake therapeutic or management techniques; and
- (May include) A videofluoroscopy for further evaluation of swallowing status and aspiration risks.

Visit Limitations



NOTE: Beginning and ending times of each therapy encounter must be documented in the client's record.

Visits are based on the CPT procedure code description. If the description does not include time, the procedure is counted as one visit, regardless of how long the procedure takes.

If time is included in the CPT procedure code description, the beginning and end times of each therapy modality must be documented in the client's medical record

- Cognitive Skills (CPT procedure codes 97532 and 97533) is considered a speech/audiology program visit and is part of the 12-visit speech/audiology program visit limitation. Each 15-minute increment will be counted as one speech/audiology program visit. These procedure codes can be billed alone or with other speech-language allowed CPT procedure codes.
- Procedures counted in the 12-visit limitation are CPT procedure codes 97532 and 97533.
- MAA allows evaluation of speech (CPT procedure code 92506) once per year, per client, per provider and it is not included in the 12-visit limitation. A second evaluation will be allowed at time of discharge for the following diagnosis codes:

348.1	Anoxic brain damage
436	Acute, but ill-defined, cerebrovascular disease
852-852.59	Subarachnoid, subdural, and extradural hemorrhage, following injury
854-854.19	Intracranial injury of other and unspecified nature

- Duplicative services for Occupational, Physical, and Speech Therapy are not allowed for the same client when both providers are performing the same or similar intervention(s).

(CPT procedure codes and descriptions are copyright 2001 American Medical Association.)

How do I request approval to exceed the limits?

For clients 21 years of age and older who need therapy visits above those allowed by diagnosis, the provider must request MAA approval to exceed the limits. The request for additional services must state the following in writing:

1. The name and Patient Identification Code (PIC) number of the client;
2. The therapist's name and provider number;
3. The prescription for therapy;
4. The number of visits were used during that calendar year;
5. The number of additional visits are needed;
6. The most recent therapy evaluation/note;
7. Expected outcomes (goals);
8. If therapy is related to an injury or illness, the date(s) of injury or illness;
9. The primary diagnosis or ICD-9-CM diagnosis code and description; and
10. The place of service.

Send your request to:

MAA – Medical Operations
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-2262

Audiology

MAA may pay for speech/audiology program services for conditions that are the result of medically recognized diseases and defects.

Who is eligible to provide audiology services? **[WAC 388-545-0700 (1)(c)]**

Audiologists who are appropriately licensed or registered to provide speech/audiology services within their state of residence to MAA clients.

What type of equipment must be used?

Audiologists must use yearly calibrated electronic equipment, according to RCW 18.35.020.

What about children with special health care needs?

Refer to MAA's Hearing Aid Program Billing Instructions for information regarding Children with Special Health Care Needs (CSHCN). (See *Important Contacts*.)

Visit Limitations



NOTE: Beginning and ending times of each therapy encounter must be documented in the client's record.

Visits are based on the CPT procedure code description. If the description does not include time, the procedure is counted as one visit, regardless of how long the procedure takes.

- Cognitive Skills (CPT procedure codes 97532 and 97533) is considered a speech/audiology program visit and is part of the 12-visit speech/audiology program visit limitation. Each 15-minute increment will be counted as one speech/audiology program visit. These procedure codes can be billed alone or with other audiology allowed CPT procedure codes.
- Procedures counted in the 12-visit limitation are CPT procedure codes 92507, 92508, 97532, and 97533.
- Evaluation of speech (CPT procedure Code 92506) is allowed once per year, per client, per provider and is not included in the 12-visit limitation. A second evaluation will be allowed at time of discharge for the following diagnosis codes:

348.1	Anoxic brain damage
436	Acute, but ill-defined, cerebrovascular disease
852-852.59	Subarachnoid, subdural, and extradural hemorrhage, following injury
854-854.1	Intracranial injury of other and unspecified nature

- For caloric vestibular testing (CPT procedure code 92543), bill one unit per irrigation. If necessary, you may bill up to four units for each ear.
- For sinusoidal vertical axis rotational testing (CPT procedure code 92546), bill 1 unit per velocity/per direction. If necessary, you may bill up to 3 units for each direction.

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How do I request approval to exceed the limits?

For clients 21 years of age and older who need therapy visits above those allowed by diagnosis, the provider must request MAA approval to exceed the limits. The request for additional services must state the following in writing:

1. The name and Patient Identification Code (PIC) number of the client;
2. The therapist's name and provider number;
3. The prescription for therapy;
4. The number of visits were used during that calendar year;
5. The number of additional visits are needed;
6. The most recent therapy evaluation/note;
7. Expected outcomes (goals);
8. If therapy is related to an injury or illness, the date(s) of injury or illness;
9. The primary diagnosis or ICD-9-CM diagnosis code and description; and
10. The place of service.

Send your request to:

MAA – Medical Operations
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-2262

Fee Schedule

Due to its licensing agreement with the American Medical Association, MAA publishes only official, brief CPT[®] procedure code descriptions. To view the full descriptions, please refer to your current CPT book.

AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS

CPT Procedure Code	Brief Description	July 1, 2004 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
92506	Speech/hearing evaluation	\$80.25	\$29.70
92507	Speech/hearing therapy	38.09	17.68
92508	Speech/hearing therapy	17.91	8.84
92510	Rehab for ear implant	82.97	54.18
92551	Pure tone hearing test, air	10.18	10.18
92611	Motion fluoroscopy/swallow	80.25	80.25
97532	Cognitive skills development	14.96	14.96
97533	Sensory integration	15.64	15.64

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AUDIOLOGISTS ONLY

CPT Procedure Code/ Modifier	Brief Description	July 1, 2004 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
69210	Remove impacted ear wax	\$29.24	\$20.18
92541	Spontaneous nystagmus test	31.96	31.96
92541-TC	Spontaneous nystagmus test	18.14	18.14
92541-26	Spontaneous nystagmus test	13.83	13.83
92542	Positional nystagmus test	32.42	32.42
92542-TC	Positional nystagmus test	21.08	21.08
92542-26	Positional nystagmus test	11.34	11.34
92543	Caloric vestibular test	14.74	14.74
92543-TC	Caloric vestibular test	11.11	11.11
92543-26	Caloric vestibular test	3.63	3.63
92544	Optokinetic nystagmus test	25.62	25.62
92544-TC	Optokinetic nystagmus test	16.78	16.78
92544-26	Optokinetic nystagmus test	8.84	8.84
92545	Oscillating tracking test	23.80	23.80
92545-TC	Oscillating tracking test	15.878	15.87
92545-26	Oscillating tracking test	7.93	7.93
92546	Sinusoidal rotational test	48.29	48.29
92546-TC	Sinusoidal rotational test	38.54	38.54
92546-26	Sinusoidal rotational test	9.75	9.75
92547	Supplemental electrical test	27.43	27.43
92552	Pure tone audiometry, air	10.88	10.88
92553	Audiometry, air & bone	16.32	16.32
92555	Speech threshold audiometry	9.29	9.29
92556	Speech audiometry, complete	14.06	14.06
92557	Comprehensive hearing test	29.47	29.47

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AUDIOLOGISTS ONLY (cont.)

CPT Procedure Code/ Modifier	Brief Description	July 1, 2004 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
92567	Tympanometry	\$12.92	\$12.92
92568	Acoustic reflex test	9.29	9.29
92569	Acoustic reflex decay test	9.97	9.97
92579	Visual audiometry (VRA)	17.91	17.91
92582	Conditioning play audiometry	17.91	17.91
92584	Electrocochleography	60.98	60.98
92585	Auditor evoke potent, compre	61.89	61.89
92585-TC	Auditor evoke potent, compre	45.11	45.11
92585-26	Auditor evoke potent, compre	16.78	16.78
92586	Evoked auditory test	45.11	45.11
92587	Evoked otoacoustic emissions; limited	36.73	36.73
92587-TC	Evoked otoacoustic emissions; limited	31.96	31.96
92587-26	Evoked otoacoustic emissions; limited	4.76	4.76
92588	Evoked auditory test	48.29	48.29
92588-TC	Evoked auditory test	36.05	36.05
92588-26	Evoked auditory test	12.24	12.24
92589	Auditory function test(s)	13.15	13.15
92601	Cochlear implt f/up exam < 7	79.34	79.34
92602	Reprogram cochlear implt < 7	55.31	55.31
92603	Cochlear implt f/up exam 7 >	52.37	52.37
92604	Reprogram cochlear implt 7 >	34.91	34.91

Note: Audiology function tests 92552-92553 can be paid separately. Other tests are included in general services.

SPEECH-LANGUAGE PATHOLOGISTS ONLY

CPT Procedure Code	Brief Description	July 1, 2004 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
92526	Oral function therapy	\$51.01	\$17.46
92597	Oral speech device eval	59.17	30.83
92605	Eval for nonspeech device rx	Bundled	
92606	Non-speech device service	Bundled	
92607	Ex for speech device rx, 1 hr	74.81	74.81
92608	Ex for speech device rx, addl	16.32	16.32
92609	Use of speech device service	37.41	37.41
92610	Evaluate swallowing function	80.25	80.25

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Billing

What is the time limit for billing?

State law requires that you present your final bill to MAA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill MAA within 365 days after you provide a service(s).
- **For clients who are not eligible at the time of service, but are later found to be eligible:** Bill MAA within 365 days from the Retroactive¹ or Delayed² certification period.
- **MAA will not pay if:**
 - ✓ The service or product is not covered by MAA;
 - ✓ The service or product is not medically necessary;
 - ✓ The client has third party coverage, and the third party pays as much as, or more than MAA allows for the service or product; or
 - ✓ MAA is not billed within the time limit indicated above.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

¹ **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

² **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be Medicaid-eligible, and then bill MAA for those services.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's medical assistance IDentification (MAID) card. An insurance carrier's billing time limit for claim submissions may vary. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at <http://maa.dshs.wa.gov> or by calling the Coordination of Benefits Section at 1-800-562-6136.

How do I bill for clients who are eligible for both Medicare and Medicaid?

Some Medicaid clients are also eligible for Medicare benefits. When you have a client who is eligible for both Medicaid and Medicare benefits, you should submit claims for that client to your Medicare intermediary or carrier, *first*. Medicare is the primary payor of claims.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when: (1) the provider accepts assignment, and (2) the total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare's allowed amount. MAA will pay up to Medicare's Allowable or MAA's allowable, whichever is less.

An **X** in the *Medicare* area on the client's MAID card (area 9) indicates Medicare enrollment.

QMB (Qualified Medicare Beneficiaries Program Limitations):

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

- If the client has a CNP or MNP MAID card in addition to the QMB MAID card, and the service you provide is covered by Medicare *and* Medicaid, MAA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.
- MAA will also reimburse for services that are *not* covered by Medicare but *are* covered under the CNP or MNP program.

QMB-MEDICARE Only (Qualified Medicare Beneficiaries)

The reimbursement criteria for this program is as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.
- If only Medicare and **not** Medicaid covers the service, MAA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.
- If Medicare does not cover or denies the service, MAA will **not** reimburse for it.

What records does MAA require me to keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. **Chart** means a summary of medical records on an individual patient. **Record** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and shall include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to DSHS or its contractor(s) and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

Notifying Clients of Their Rights (Advanced Directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. Insured's I.D. No.: Required. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC
MC010667JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this:
J-100257LEE B.

2. Patient's Name: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. Patient's Birthdate: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address:** Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name:** Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, PCCM, Medicare, Indian Health, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related to:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.

- | | |
|--|---|
| <p>11c. <u>Insurance Plan Name or Program Name:</u> Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. <i>(Note: This may or may not be associated with a group plan.)</i></p> <p>11d. <u>Is There Another Health Benefit Plan?:</u> Required if the client has secondary insurance. Indicate <i>yes</i> or <i>no</i>. If yes, you should have completed <i>fields 9a.-d</i>. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check <i>yes</i>. If 11d. is left blank, the claim may be processed and denied in error.</p> <p>17. <u>Name of Referring Physician or Other Source:</u> Required. Enter the referring physician or Primary Care Case Manager name.</p> <p>17a. <u>I.D. Number of Referring Physician:</u> Enter the seven-digit, MAA-assigned identification number of the provider who <i>referred or ordered</i> the medical service; <u>OR</u> 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is <u>not</u> in this field when you bill MAA, the claim will be denied.</p> <p>19. <u>Reserved for Local Use:</u> Enter "T" for school contracted services that are noted in the client's IEP or IFSP. Direct entry and electronic billers must use their appropriate field.</p> | <p>21. <u>Diagnosis or Nature of Illness or Injury:</u> When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.</p> <p>22. <u>Medicaid Resubmission:</u> When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the <i>claim number</i> listed on the Remittance and Status Report.)</p> <p>23. <u>Prior Authorization Number for Limitation Extensions:</u> When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.</p> <p>24. <u>Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.</u></p> <p>24A. <u>Date(s) of Service:</u> Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 04, 1999 = 070499). Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).</p> |
|--|---|

24B. Place of Service: Required. These are the only appropriate codes for this program:

<u>Code Number</u>	<u>To Be Used For</u>
2	Outpatient
3	Office
4	Home
9	Other

24C. Type of Service: Required. Enter a 3 for all services billed.

24D. Procedures, Services or Supplies CPT/HCPCS: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

24E. Diagnosis Code: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. \$ Charges: Required. Enter your usual and customary charge for the service performed. Do not include dollar signs or decimals in this field.

24G. Days or Units: Required. Enter the appropriate number of units.

25. Federal Tax I.D. Number: Leave this field blank.

26. Your Patient's Account No.: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. Total Charge: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. Amount Paid: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. Balance Due: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number: Required. Put the *Name, Address, and Telephone Number* on all claim forms.

Group: Enter the group number assigned by MAA. This is the seven-digit number identifying the entity (i.e., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

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HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY		7. INSURED'S ADDRESS (No., Street)	
STATE		CITY	
ZIP CODE		STATE	
TELEPHONE (Include Area Code) ()		ZIP CODE	
TELEPHONE (INCLUDE AREA CODE) ()		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____			

14. DATE OF CURRENT: MM DD YY		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
19. RESERVED FOR LOCAL USE		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		23. PRIOR AUTHORIZATION NUMBER	
1. _____		3. _____	
2. _____		4. _____	

A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
From	To					CPT/HCPCS	MODIFIER														
MM	DD	YY	MM	DD	YY																

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. \$ TOTAL CHARGE		29. \$ AMOUNT PAID		30. \$ BALANCE DUE					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #							
SIGNED _____				DATE _____				PIN# _____				GRP# _____			

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark “XO,” in box 19 on crossover claim?

A: The “XO” allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the HCFA-1500 claim form.

Q: What fields do I use for HCFA-1500 Medicare information?

A: <u>In Field:</u>	<u>Please Enter:</u>
19	an “XO”
24D	total combined coinsurance and deductible
24K	Medicare’s allowed charges
29	Medicare’s total deductible
30	Medicare’s total payment
32	Medicare’s EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate “XO.”

Q: How do my claims reach Medicaid?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *“This information is being sent to either a private insurer or Medicaid fiscal agent,”* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, you should bill MAA on the HCFA-1500 claim form.

If **Medicare denies** a service, bill MAA using the HCFA-1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. Insured's I.D. No.: Required. Enter the Medicaid Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the MAID card. This information is obtained from the client's current monthly MAID card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. Patient's Name: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. Patient's Birthdate: Required. Enter the birthdate of the Medicaid client.

4. Insured's Name (Last Name, First Name, Middle Initial): When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. Patient's Address: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).

9. Other Insured's Name: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field

- | | |
|---|--|
| <p>10. <u>Is Patient's Condition Related To:</u> Required. Check <i>yes</i> or <i>no</i> to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in <i>field 24</i>. <i>Indicate the name of the coverage source in field 10d</i> (L&I, name of insurance company, etc.).</p> <p>11. <u>Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:</u> Primary insurance. When applicable. This information applies to the insured person listed in <i>field 4</i>. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.</p> <p>11a. <u>Insured's Date of Birth:</u> Primary insurance. When applicable, enter the insured's birthdate, if different from <i>field 3</i>.</p> <p>11b. <u>Employer's Name or School Name:</u> Primary insurance. When applicable, enter the insured's employer's name or school name.</p> <p>11c. <u>Insurance Plan Name or Program Name:</u> Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. (<i>Note: This may or may not be associated with a group plan.</i>)</p> | <p>11d. <u>Is There Another Health Benefit Plan?:</u> Required if the client has secondary insurance. Indicate <i>yes</i> or <i>no</i>. If yes, you should have completed <i>fields 9a.-d</i>. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check <i>yes</i>. If 11d. is left blank, the claim may be processed and denied in error.</p> <p>19. <u>Reserved For Local Use - Required. When Medicare allows services, enter XO to indicate this is a crossover claim.</u></p> <p>22. <u>Medicaid Resubmission:</u> When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the <i>claim number</i> listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).</p> <p>24. <u>Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.</u></p> <p>24A. <u>Date(s) of Service:</u> Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 4, 1999 = 070499). Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).</p> |
|---|--|

24B. Place of Service: Required. These are the only appropriate codes for this program:

<u>Code Number</u>	<u>To Be Used For</u>
--------------------	-----------------------

2	Outpatient
3	Office
4	Home
9	Other

24C. Type of Service: Required. Enter a 3.

24D. Procedures, Services or Supplies CPT/HCPCS: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed. **Coinsurance and Deductible:** Enter the total combined coinsurance and deductible for each service in the space to the right of the modifier on each detail line.

24E. Diagnosis Code: Enter appropriate diagnosis code for condition.

24F. \$ Charges: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. Days Or Units: Required. Enter the appropriate number of units.

24K. Reserved for Local Use: Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. Your Patient's Account No.: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading Patient Account Number.

27. Accept Assignment: Required. Check yes.

28. Total Charge: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. Amount Paid: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. Balance Due: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility
Where Services Are Rendered:**
Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing
Name, Address, Zip Code and
Phone #:** Required. Enter the pharmacy's *Name, Address*, and *Phone #* on all claim forms. Enter your seven-digit pharmacy provider number (which begins with six [6] here. **Do not use your NABP number for Medicare/Medicaid crossover claims.**

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		CHAMPUS <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (VA File #)		GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>		FECA BLK LUNG (SSN) <input type="checkbox"/>		OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)								3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial)															
5. PATIENT'S ADDRESS (No., Street)								6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)															
CITY				STATE				8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY				STATE											
ZIP CODE				TELEPHONE (Include Area Code) ()				Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE				TELEPHONE (INCLUDE AREA CODE) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE				11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.															
a. OTHER INSURED'S POLICY OR GROUP NUMBER								b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				c. EMPLOYER'S NAME OR SCHOOL NAME				d. INSURANCE PLAN NAME OR PROGRAM NAME											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____											
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)								15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY															
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE								17a. I.D. NUMBER OF REFERRING PHYSICIAN				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. RESERVED FOR LOCAL USE								20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____								23. PRIOR AUTHORIZATION NUMBER																			
24. A		B		C		D		E		F		G		H		I		J		K							
DATE(S) OF SERVICE From MM DD YY To MM DD YY		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE							
1																											
2																											
3																											
4																											
5																											
6																											
25. FEDERAL TAX I.D. NUMBER				SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. \$ TOTAL CHARGE				29. \$ AMOUNT PAID				30. \$ BALANCE DUE			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____								32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)								33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____											

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY		7. INSURED'S ADDRESS (No., Street)	
STATE		CITY	
ZIP CODE		STATE	
TELEPHONE (Include Area Code) ()		ZIP CODE	
TELEPHONE (INCLUDE AREA CODE) ()		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	

14. DATE OF CURRENT: MM DD YY		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
19. RESERVED FOR LOCAL USE		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		23. PRIOR AUTHORIZATION NUMBER	

A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
From	To					CPT/HCPCS	MODIFIER														
MM	DD	YY	MM	DD	YY																
1																					
2																					
3																					
4																					
5																					
6																					

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. \$ TOTAL CHARGE		29. \$ AMOUNT PAID		30. \$ BALANCE DUE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____							